

## Testis Advanced Case #1 Answer Sheet

FIELD#	FIELD NAME	CODE AND RATIONALE/DOCUMENTATION	
PATIENT IDENTIFICATION			
1	Medical Record #	888801	From record
2	Accession #	2007xxxxx	
3	Sequence #	00	No history other malignancies
4	Patient Name	Testaverde, Tom	From record
5	Race 1	01	White per H&P 8/7/07
6	Spanish Origin	0	No mention of Hispanic origin
7	Sex	1	Male
CANCER IDENTIFICATION			
8	Class of Case	1	Dx and Tx at facility
9	DATE 1st Contact	08/02/2007	Ultrasound
10	DATE Initial Dx	08/07/2007	Pathology report
11	Primary Site	C621	Descended testicle
12	Laterality	1	Right
13	Histology	9061	Seminoma ('classic type' per Path Report)
14	Behavior	3	Malignant, primary tumor
15	Grade	9	No grade documented on path
16	Diagnostic Confirmation	1	Path report
17	Ambiguous Terminology Dx	0	Definitive statement malignancy (path report)
18	Date of Conclusive Dx	88/88/8888	Dx made with definitive statement
19	Date of Multiple Tumors	00/00/0000	Single tumor
20	Mult Tumors Reported as 1 Primary	00	Single tumor
21	Multiplicity Counter	01	1 tumor only
STAGE OF DISEASE AT DIAGNOSIS			
22	DATE Surg Dx/Stage Procedure	00/00/0000	No Surg Dx/Stage procedure
23	Surg Dx/Stage Procedure Code	00	No Surg Dx/Stage procedure
24	Clinical T	88 vs X	Not applicable, no clinical T
25	Clinical N	0	Neg PE (Poss adenop on CT, but PET neg)
26	Clinical M	0	No distant mets documented
27	Clinical Stage Group	1	(T88 uses pT to stage, N0M0)
28	Clinical Stage Descriptor	0	No descriptors
29	Clinical Staged By	1	Per RT consult and summary note
30	Pathologic T	2	Involvement tunica vaginalis per path
31	Pathologic N	X	No LNs removed
32	Pathologic M		Leave blank per AJCC
33	Pathologic Stage Group	99	(T2NxM blank)
34	Pathologic Stage Descriptor	0	No descriptors
35	Pathologic Staged By	2	Pathologist
36	SEER Summary Stage 2000	1	Localized
COLLABORATIVE STAGING			
37	CS Tumor Size	030	3 cm per path
38	CS Extension	20	Tunica vaginalis per path
39	CS Tumor Size/Ext Eval	3	Orchiectomy specimen
40	CS Lymph Nodes	00	Neg LNs per PE, PET
41	CS Reg Nodes Eval	0	Clinical info (PE, PET)
42	Regional Nodes Examined	00	No nodes examined
43	Regional Nodes Positive	98	No nodes examined
44	CS Mets at Dx	00	No mets seen on PET scan
45	CS Mets Eval	0	Clinical info (PE, PET)
46	CS Site-Specific Factor 1	020	AFP negative per H&P, RT Clinic note
47	CS Site-Specific Factor 2	020	HCG negative per H&P, RT Clinic note
48	CS Site-Specific Factor 3	999	No documentation LDH done

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49	CS Site-Specific Factor 4	001	Radical orchiectomy done
50	CS Site-Specific Factor 5	000	No LN mets (clinically)
51	CS Site-Specific Factor 6	888	Not applicable
<b>FIRST COURSE OF TREATMENT (FCOT)</b>			
52	DATE of FCOT	08/07/2007	Orchiectomy
53	DATE 1st Surgical Procedure	08/07/2007	Orchiectomy
54	DATE Most Definitive Surg Primary	08/07/2007	Orchiectomy
55	Surg Procedure Primary Site	40	Orchiectomy with spermatic cord
56	Surg Margins Primary Site	0	Margins negative per path
57	Scope Regional LN Surgery	0	No LNs removed
58	Surg Procedure Other Site	0	No other surgery
59	DATE Surg Discharge	08/07/2007 vs 08/xx or 08/99/2007	Orchiectomy usually 1-day outpatient surgery versus unknown date (chart would have better documentation)
60	Readmit Same Hosp w/in 30 Days	0	No readmit documented
61	Reason NO Surg Primary Site	0	Surgery done
62	DATE Radiation Started	09/14/2007	RT started per summary
63	DATE Radiation Ended	10/11/2007	RT ended per summary
64	Location of Radiation Treatment	1	At same location as surgery
65	Radiation Treatment Volume	23	Lower ext field (para-aortic LNs)
66	Regional Treatment Modality	25	18MV per RT summary
67	Regional Dose: cGy	02500	25 Gy per RT summary
68	Boost Treatment Modality	00	Not done
69	Boost Dose: cGy	00000	Not done
70	Number Treatments per Volume	20	20 Fractions per RT summary
71	Radiation/Surgery Sequence	3	RT after surgery
72	Reason NO Radiation	0	RT done
73	DATE Systemic Therapy Started	00/00/0000	Not done
74	Chemotherapy Code	00	Not done
75	Hormone Code	00	Not done
76	Immunotherapy Code	00	Not done
77	Hematologic Trspl & Endo Code	00	Not done
78	Systemic/Surgery Sequence	0	No sequence
79	DATE Other Treatment Started	00/00/0000	No other treatment
80	Other Treatment Code	0	Not done
81	Palliative Treatment Code	0	Not done
<b>RECURRENCE</b>			
82	DATE 1st Recurrence	00/00/0000	No recurrence documented
83	Type 1st Recurrence	00	No recurrence documented
84	DATE Last Contact/Death	10/11/2007	Last date documented (RT summary)
85	Vital Status	1	Pt alive
86	Cancer Status	1	No evidence disease, curative tx given
<b>CASE ADMINISTRATION</b>			
87	Is Case Complete?	Yes	Date Surg Discharge could be obtained from full medical record for total completion of abstract